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ABSTRACT

Described is a preschool program designed to provide early intervention in special education for severely handicapped children, which is noted to have been expanded to include children with severe behavioral disturbances and cognitive and developmental disabilities. The program is reported to serve nine children for 3 hours daily five days a week, to provide teacher training, to include parent training, and to present an opportunity for educational and behavioral research. Brief sections cover a review of relevant literature, responsibilities of staff members and teachers or parents in training, curriculum, schedules, rules and procedures, and a description of the three phases of the parent training program. Included are individual case study profiles of eight children. Appended materials include copies of forms used at the preschool, such as a daily lesson plan, progress report, student teacher evaluation sheet, and clinic evaluation form. (IM)

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NON-CATEGORICAL PRESCHOOL MODEL: TEACHER AND PARENT TRAINING MANUAL

PRESCHOOL UNIT

Clinic for Exceptional Children
Department of Special Education
University of Southern California

By:

Neil C. Riley, M.Ed.
Reanne Singer, M.Ed.
Judith M. Jackson, M.A.

Editor

Robert B. Rutherford, Jr., Ph.D.

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In the fall of 1972, graduate students in the Department of Special Education at the University of Southern California, in an attempt to broaden the services of the Clinic for Exceptional Children, began initial steps in formulating a preschool for severely and profoundly handicapped children. The program within this preschool was based on the following orientation: the prime importance was the commitment to service for severely handicapped children within a non-categorical framework. Children were selected for placement in the preschool on the basis of the severity rather than the category of the handicap. An equally important commitment of the preschool was the involvement and training of parents in handling their children's behavioral and learning problems.

The facility, which is located in the School of Education at the University of Southern California, is a self-contained area comprised of a classroom, six individual training rooms, and a parent conference room. The preschool program, containing nine children, operates three hours daily five days a week. The program provides service to children and their parents, and opportunity for educational and behavioral research, and teacher training at the graduate level.

This manual describes and discusses preschool-related activities and the implications which may be derived from our experiences and empirical findings. The report represents the efforts and dedication of a great many individuals who are part of the Clinic staff or who were associated with the preschool during the past five years.

The information contained in this monograph has been developed and expanded from the original ERIC document "Non-Categorical Model Preschool Program" (EDRS #078 616) published through the CEC Information Center for Exceptional Children.

As the Clinic preschool program has evolved, the results can be seen in the eyes of the children and their parents. Special thanks must be extended to each parent for their cooperation, insights and dedication during the past four years. Above all else has been the ability of the staff to profit and grow along with the children.

Robert B. Rutherford, Jr.

Neil Riley

Reanne Singer

Judith Jackson

REVIEW OF LITERATURE

EARLY INTERVENTION

Early education for the handicapped child is not merely a downward extension of elementary education, but a field of study in itself. Martin (1970) points out that early intervention may prevent the need for later special education at the elementary and secondary levels. Furthermore, the severity of the handicapping condition may be reduced in addition to preventing possible secondary emotional problems which often accompany the handicap. In fact, to a large extent, the observable value of early experience for the handicapped child has led to the generalization that early intervention is effective for all children.

Kirk (1958) discovered that exogenous handicapped children and environmentally deprived children benefited the most from early intervention programs. Caldwell and Richmond (1968) substantiated Kirk's findings by showing a high positive correlation between extent of deprivation of the family from which the children came and the extent to which the children responded to the enrichment program. Flint (1966) studied 83 infants and preschool institutionalized children from emotionally and culturally deprived backgrounds. After an intensive early intervention program, the children gradually showed significant improvement in emotional, social, and speech development and became increasingly competent in self-help skills.

While many early intervention programs for the disadvantaged have been successful, it is necessary to examine the reasons for the apparent failure of the Head Start program. Spicker (1971) contends that the failure of Head Start should not reflect on the effectiveness of all early childhood programs. New models concerned with intellectual and

cognitive development, perceptual-motor development, and the acquisition of academic skills have been developed since the Head Start program, which was based primarily on the traditional nursery school curriculum. As Spicker points out, many variable factors such as optimum age for intervention, curriculum models, home intervention, and differing lengths of programs, affect the success of early intervention programs.

A major question of administrators and teachers concerns the educability of intelligence. To date, early intervention programs for disadvantaged children have resulted in significant gains in cognitive and intellectual development. Can these findings be generalized to the mentally retarded child whose potential intellectual capacities are much more limited? As far back as 1909, Binet asserted that mental retardation was "curable" by education. Kirk (1958), in a study of 81 mentally retarded children between the ages of three and six, found that 70% of the children who received preschool training showed an acceleration in rates of cognitive growth and retained that level in a subsequent follow-up study. Forbes and Raschick (1969) studied an academic compensatory education preschool program for educable mentally retarded children from three to five years of age. Using behavior modification techniques, the program reported a 17-month average gain in language over 7½ months, improved behavior and self-concepts, longer attention spans and ability to delay gratification, and substantial gains in academic skills.

Although early intervention programs are relatively new in the field of education, their applicability is widespread, as indicated by the many programs designed to educate various types of exceptional children. Brunner (1972) reported on an early school admissions program in which successful reduction in the occurrence of learning disabilities was

achieved due to early identification and correction of problems and focus on individual strengths and needs at an early stage. Adkins and Waler (1972) stated the need of learning disabled children to start school at an earlier age in a special setting not only to acquire academic skills, but also to prevent or reduce in severity concomittant future educational, emotional, social, and vocational handicaps. Dunn (1969), described child development and reading from a pediatric viewpoint, emphasized the need to catch the children before they experience failure in the reading program in the elementary school.

Block (1971) described an early childhood education program for emotionally disturbed children without language development that emphasized verbal learning. Children with diagnosis of emotional disturbances or neurological handicap with severely impaired emotional, intellectual, and social functioning made significant improvements in the program.

Ross (1972) discussed the early management of aural rehabilitation with the objective of minimizing the need for later aural rehabilitation. The stated rationale for early training was the prevention of the development of secondary learning and behavioral problems that may limit the effective use of residual hearing. In the area of language disorders, Fisher (1971) emphasizes the importance of early auditory training for children and the significance of the family environment on the children's early language instruction. In a study by Vernon and Koh (1971), results of an oral preschool education for deaf children were compared to the absence of preschool training, but an oral environment without manual communication, and the absence of preschool training and an environment of early manual communication. Those children who had early manual communication and no preschool were found to be superior academically

and in language skills to children who had had intensive 3-year preschool training without manual communication training. Those who had an oral environment but no preschool were equal in academic achievement, oral skills, and written language to those who had had oral preschool. Thus, even though the formal preschool program apparently made no significant difference, children in all three groups benefited from the early intervention.

Rohiver (1971) questions the value of early childhood education, stating that early childhood may be an inefficient period in which to teach skills more readily acquired in adolescence. He also advocates that the present nature of early childhood should be changed on the basis of his hypothesis that the longer formal instruction is delayed, up to certain limits, the greater the period of plasticity and the higher the ultimate level of achievement. However, the great majority of the research on early intervention explicitly states that the negative effects of handicapping conditions on such important aspects of development as intellectual functioning, language, self-concept, motivation, health, and physical being, as well as the social and emotional domains, could best be combated through intervention during the preschool years. As Gallagher contends, "The establishment of quality preschool services for handicapped children is a clear priority for special education. Our knowledge of research in child development is consistent with that goal, as is our accumulated experiences in special education" (1973:182).

REVIEW OF LITERATURE

PARENT TRAINING

Although it has long been assumed that parent education can make a meaningful contribution to child development, recent early childhood programs often utilize parent participation on the premise that parents can make a unique active contribution to the development of their children. Rather than functioning as receivers of information and advice from experts, parents are now assuming full responsibility with educators in developing educational programs for their children.

Results of research by Blatt and Garfunkel (1969) suggest that it is not enough to provide preschool disadvantaged children with an enriched educational opportunity, since the children were influenced more by parents in the home setting. In a parent education program at the University of Florida, Gordon (1969) found that children in the experimental program, which included training parents in child development and interpersonal relationships, progressed more rapidly than those children whose parents did not receive the training. Lambie and Weikart (1970) stressed that the process of a teacher, a mother, and an infant getting ready to learn together was a critical one. In an attempt to assess the influence of parent involvement in preschool programs for disadvantaged children, Radin (1968) conducted a study in a preschool in Ypsilanti, Michigan. One hundred four-year old children were served, half of whom were black, and half white. Parents were trained not only in curriculum which centered on cognitive functioning, but also in behavioral management skills. Although the results of Radin's current program are unavailable, an earlier pilot project produced significant gains on the Stanford-

Bilet and the HYP. Wargo, Campeau, Tallmadge (1971), in a federally funded Verbal Interaction Project found results similar to those of Radin's. In an attempt to modify early cognitive experience of disadvantaged young children, children were provided with a home-based verbal stimulation program. Parents actively participated in all aspects of the program. On the basis of pre and post tests, the investigators concluded that subjects had made a significant mean IQ gain of 17 points. These results were validated by a follow-up test administered 30 months after the pretest. A preliminary report by Caldwell, Elardo, and Elardo (1972), in a sudy at the University of Arkansas, shows results contrary to those by Radin and Wargo, et al. Four treatment groups each containing 30-32 infants were used to illuminate the success of an intervention program stressing the parent-child unit. Results for three of the treatment groups showed a decline on the Bayley Scales of Infant Development; however, no data is available for the fourth group. Although treatment groups showed a decline on post-test, the authors concluded that their intervention may have a cumulative effect which could appear at a later date. Research trends indicate that parent involvement in preschool programs for disadvantaged children results in significant gains in a child's cognitive and emotional growth.

Although parent participation has been used most often in relation to programs for disadvantaged children, it applies with equal validity to the education of other types of exceptional children. In a program for ten blind infants Fraiberg, Smith, and Adelson (1969) focused upon the first 18 months of life during the "critical period of ego formation." The authors concluded that great importance must be placed on the promotion of the "love bonds" between a blind infant and his parents.

Luterman (1967) reported on a program involving parents and their deaf preschool children which was initiated at the Robbins Speech and Hearing Center in Boston. Although problems arose inherent in working with parents rather than the child, at the conclusion of the program the group appeared to manifest progress. Horton (1968), at the Bill Wilkerson Speech and Hearing Clinic in Nashville, did not attempt to transform the parent into a teacher, but rather capitalized on the parent's natural way of stimulating the child. While no objective evaluation of the program was made, there was indication that the program had distinct assets.

Jackson, Evenson, and Elzey (1971) conducted an experimental project for preschool multiply handicapped rubella children. Parents participated in the program in a variety of ways such as assisting in the classroom and working as paid aides. The children showed cognitive gains at the conclusion of the program. However, the authors acknowledged that it was difficult to attribute the results to parent participation and not other intervening variables such as maturation. Hunter and Schueman (1967) developed a program for retarded infants at the Shield Institute for Retarded Children in New York. The program's main emphasis was upon the mental health of the family and a multidisciplinary training program for mother and child. On the basis of pre and post evaluation by teachers, it was concluded that the home training had a beneficial effect. In the absence of a control group, however, the investigators caution against misinterpretation. A project at the West Suburban Special Education Center in Illinois used parents as volunteer aides in the classroom for TMR children. Some children in the school also had other handicaps. Benson and Ross (1972) conclude that the children

gained in such areas as self-care, language, and concepts as a result of the program. Another important asset of the program was the carry-over of tutoring activities to the home.

At the League School in New York an effort was made to improve the functioning of young mentally ill children through work with their parents. While the results showed no significant gains in IQ scores between groups, the experimental subjects did show gains in six of seven subcategories of the Vineland.

A one year project at United Cerebral Palsy of Queens evaluated the effects of an intervention on neurologically impaired children and their families. An informal teacher rating scale served as pre and post treatment evaluation of the children's physical, social, and intellectual growth. Results showed a positive change on all these variables.

Slater (1971) focused on kindergarten children with learning disabilities and their mothers. Post test results indicate that children whose parents were involved in training did significantly better than the children whose parents were not involved in training on the Bender-Gestalt Test. These gains, however, were not indicated on the Metropolitan Readiness Test or a human figure drawing test. Upon comparison of parent programs for the disadvantaged and those for handicapped children, there is an evident need for more formal evaluations of such programs. Although most programs for the handicapped appear to show significant changes when parents are involved, these results require substantiation.

Calvert (1971) stressed the need for parent involvement as a purposeful part of early education programs. Olshin (1971) concurs with this view when he expressed the belief that the parents can often be regarded as the most important intervening agent between preschool and child.

The recent emphasis on parent involvement is reflected by Zigler (1971) who states that the program that "impacts the child the most" is one that involves the parent interacting with his own child. Considering the limited contact a professional can have with the child, it is imperative that the parent be involved in implementing the child's educational program.

REVIEW OF LITERATURE

NON-CATEGORICAL

A significant trend in special education is toward a non-categorical approach in educating young handicapped children. Analysis of social and emotional factors in learning disabilities demands that a child needs to be viewed first as a child with normal needs and second as an individual with a handicap. Trippe states that "...the physical environment must be made for the delicate child. The blind child must learn braille and must learn to find his way around with relative independence. The retarded child may be limited in rate of progress and expected level of development. The differences in educational programming, however, are most often related to physical arrangements and the need for additional or alternative skills. The ways of learning are no different" (1966:244). Trippe also points out that preoccupation over differences between groups persists even though educators are becoming more aware that many children are diagnosed as mentally retarded and emotionally disturbed on a socio-economic basis.

Reynolds contends that educators should realize that a "category" is merely a delusion, and that no actual child possesses all of the characteristics of a given category. As a result, it is impossible for any two children within a category to be alike in all respects. As an alternative, Reynolds proposed that a different approach be used in which each of the traditional categories of exceptional children could be considered as representing complex sets of variables. Reynolds distinguishes between two general types of variables which he refers to

as source variables and decision variables. Source variables represent the sources of the educational problems, such as mental retardation or emotional disturbance, which serve to alert educators to existing or potential problems. Decision variables, on the other hand, indicate an analysis of the problem, rather than a mere label, which hopefully points to appropriate educational techniques and procedures. As Reynolds explains, decision variables may not always refer to characteristics of the child, but rather to the environmental situation in which he interacts. Reynolds contends that this pattern of thinking, placing prime significance on the unique needs and variables of each individual child rather than on general categorical characteristics, should promote the current trends of removal of labels which reflect "fragile educational decisions and placements." Dunn supports this position by stating that "...the need for disability labels is reduced. In their stead we may need to substitute labels which describe the educational intervention needed" (1968:15).

Lilly proposed that educators move from defining exceptional children to defining exceptional situations within the school:

> An exceptional school situation is one in which productive interaction between a student and his teacher has been limited to such an extent that external intervention is deemed necessary by the teacher to cope with the problem (1971:3).

From such a definition, Lilly contends that a system would emerge in which "it is not assumed that all school problems are centered in the child and that removal of children from problem situations is beneficial for everyone involved."

Concerning the great amount of research on the efficiency of special classes, Lilly points out that these efficacy studies have

produced conflicting evidence, although possibly a greater amount of the data suggests that special programs actually do not produce superior results to regular class settings. Goldstein, Moss, and Jordan (1965) found that EMR's in the regular class achieved significantly higher reading scores at the end of a two-year period, although EMR children in the self-contained class caught up to the former group at the end of a four-year period. Although results concerning efficacy studies are indeed inconclusive, the fact remains that the effectiveness of the traditional special classroom based upon categorization of children is highly questionable.

Vreeland contends that "it is unreal to talk of continuing to add new categories of exceptionality, of establishing and identifying the characteristics of the new exceptionalities...when the un-met needs of untold numbers of children continued to be ignored. Rather, a vital reorganization of thinking and programming in regard to children's needs throughout the entire educational enterprise is required by the challenge of the day" (1970:4).

Empey (1967) feels that "when there is no consensus on objectives, there is no logical means for choosing one approach over another...It would not make sense to initiate an experimental effort unless objectives were made explicit and a set of priorities chosen" (1967:4-5). If the goal of an educational program is directed toward the remediation of specific deficits characteristic of a single exceptionality, the traditional categorical-based program may be appropriate. However, if the program encompasses the broader goal of providing the child not only with remediation of individual problems, but also with the opportunity for

educational focus on cognitive, social and emotional growth, the non-categorical approach may be most effective.

Preschool Staff

The core and reading staff members involved in planning and activating the preschool program are all trainees from the Department of Special Education at the University of Southern California.

The dissemination of responsibilities for the staff include:

Dr. Robert Rutherford - Director of the Clinic for Exceptional Children
Neil Riley - Coordinator, and Program Evaluator
Reanne Singer - Master Teacher
Judith Jackson - Supervisor of Teacher Training
Mike Brown - Supervisor of Behavioral Management and Parent Training
Paul Cooney - Supervisor of Behavioral Management and Parent Training

The responsibilities of each core staff member are carefully defined to maximize capabilities and to delineate channels of communication.

The tasks of this group include: 1) observation and evaluation of existing preschool programs, 2) investigating the possibility of a grant which will help fund the program in the future, 3) developing materials for use with preschool children, 4) constructing a room environment which is conducive to meeting the educational needs of children, 5) planning a budget for the academic year based on private and public fees, and 6) delineating responsibilities of staff members.

Responsibilities of Teachers in Training

Teaching

1) Planning and conducting activities for one or two children as a primary teacher, team teacher or back-up teacher during the individual sessions that include language, conceptual development, gross motor, self-help and social/adaptive behavior.

2) Alternate weekly with other teachers in sharing responsibilities for planning and conducting gross/fine motor, and snack periods.

3) Supervise playtime, snacktime and other group activities such as art and music.

4) Teaching hours are Monday - Thursday, from 9:30 - 12:30.

Meetings

1) Meet once weekly with your supervisor to discuss curriculum and materials, progress, etc.

2) Team meetings once weekly to discuss a particular child and/or parent.

3) Staff meetings once weekly.

Planning

1) Develop lesson plans for each child during the periods of individual instruction based on prior task analysis.

2) Develop appropriate curriculum materials during the periods of individual instruction based upon specific objectives.

3) Planning for group activities such as snack time, play sessions, etc. on a rotating basis.

4) Writing monthly progress reports for each child, including a final semester report. Varify new objectives, evaluation procedures.

5) Helping to prepare with your supervisor, appropriate developmental and longitudinal programs for one particular child based upon both educational diagnosis and individual observation and recording of relevant academic/social behaviors.

Forms and Miscellaneous

1) Complete "longitudinal and developmental" form weekly.
2) Complete list of necessary materials for the upcoming week.
3) Complete evaluation of own progress bi-weekly.
4) Complete evaluation of supervisor progress bi-weekly.
5) Complete progress report on primary child monthly.
6) Complete final report on primary child at the end of the semester.
7) Complete Clinic preschool evaluation at end of semester.
8) Call the Clinic the day before an anticipated absence or no later than 9:30 on the day of the absence.
9) Submit weekly anecdotal records to the Parent Training Supervisor.
10) Fill out and return progress forms every month on your child and home interventions.

Meetings

Meet once weekly with the primary teacher who works with your child to discuss progress.

Planning

1) Develop lesson plans for each child during the periods of individual instruction based on prior task analysis.
2) Develop appropriate curriculum materials during the periods of individual instruction based upon specific objectives.
3) Planning for group activities such as snack time, play sessions, etc., on a rotating basis.

4) Writing monthly progress reports for each child, including a final semester report. Varify new objectives, evaluation procedures.

Forms and Miscellaneous

1) Complete evaluation of own progress bi-weekly.
2) Complete evaluation of supervisor progress bi-weekly.
3) Complete progress report on primary child monthly.
4) Complete Clinic preschool evaluation at end of semester.

The Clinic preschool telephone number is:

(213) 746-6277 or 746-6012

Responsibilities of the Supervisors of Teacher Training

Supervision

1) Establishing initial evaluation procedures for teacher-training based upon competency based programming.
2) Supervise all planning with your primary teacher(s).
3) Write specific objectives for teachers in the areas of curriculum and instruction.

Meetings

1) Meet once weekly with your primary teacher(s) to discuss curriculum, materials, educational planning, etc.
2) Attend staff meetings once weekly.
3) Attend core staff meeting once weekly.

Planning

1) Help primary teachers design lesson plans, etc.
2) Writing monthly progress reports on your primary teachers, including a final semester report to be placed in the teachers' departmental files.
3) Helping to prepare with your primary teacher appropriate developmental/ longitudinal programs for the individual children.

Forms and Miscellaneous

1) Complete evaluation of primary teacher(s) monthly.
2) Complete self-evaluation monthly.
3) Complete Clinic preschool evaluation form at end of the semester.

Parent Responsibilities

1) Attend and participate in the Preschool Project at least 3 days per week for a total of 6 hours per week.
2) Make up any absence by attending the next session with the Parent Training Supervisor.
3) Call the Clinic the day before an anticipated absence, or no later than 9:30 on the day of the absence.
4) Submit weekly anecdotal records to the Parent Training Supervisor.
5) Fill out and return progress forms every month on your child, and home interventions.

Meetings

Meet once weekly with the primary teacher who works with your child to discuss progress.

Planning

1) Develop lesson plans for each child during the periods of individual instruction based on prior task analysis.
2) Develop appropriate curriculum materials during the periods of individual instruction based upon specific objectives.
3) Planning for group activities such as snack time, play sessions, etc., on a rotating basis.
4) Writing monthly progress reports for each child, including a final semester report. Verify new objectives, evaluation procedures.

Forms and Miscellaneous

1) Complete evaluation of own progress bi-weekly.
2) Complete evaluation of supervisor progress bi-weekly.
3) Complete progress report on primary child monthly.
4) Complete Clinic preschool evaluation at end of semester.

Responsibilities of the Supervisors of Behavioral Management and Parent Training

Parent Training

1) Introducing parents to Phase I-III of Parent Training program.
2) Scheduling the parents for direct involvement in the Preschool with the help of the Supervisors.
3) Designing lesson plans and activities which will be used in formal training of the parents.
4) Explaining parent responsibilities while working in the classroom.
5) Providing feedback to parents concerning classroom participation and home intervention.
6) Setting criteria and competencies necessary to receive the certification in Early Childhood Education and Developmental Disabilities for interested parents.

Meetings

1) Being present during initial classroom training of all parents.
2) Attend staff meetings once weekly.
3) Attend core staff meetings once weekly.
4) Meet when needed with promary teachers and parents to facilitate communication.

Planning

1) Help primary teachers understand parental needs and expectations concerning their child.
2) Helping primary teachers understand and utilize similar behavioral interventions as used by the parents.

Forms and Miscellaneous

1) Writing monthly progress reports on parents progress in parent training, home intervention, with specific monthly objectives to accomplish goals.
2) Complete self-evaluation monthly.
3) Complete Clinic preschool evaluation form at end of semester.

Responsibilities of the Coordinator of Preschool Staff and Program Evaluator

Coordination

1) Scheduling and coordinating activities of all staff.
2) Initiate screening and assessment of applicants for the preschool program.
3) Disseminating information concerning the preschool program through written and personal contacts to special education facilities in the Los Angeles area.
4) Establishing the agenda for weekly preschool staff meetings.
5) Evaluating the effectiveness of core positions and preschool accountability formats.
6) Coordinate the monthly budget and handle all financial arrangements with Regional Center, DPSS and parents.
7) Add support to any core staff member with their responsibilities.
8) Facilitating communication and interaction both within the preschool and between the staff and faculty of the Department of Special Education.

Meetings

1) Attend all meetings and coordinate weekly staff agenda.
2) Attend all core staff meetings and coordinate weekly agenda.

Planning

1) Write monthly reports on any primary teachers/personnel not covered by a Supervisor.
2) Evaluate core staff positions and continuity in preschool structure and organizational design.
3) Discuss in detail with the staff any additional placement of children.
4) Meet once monthly with the Director to present the fiscal statement and current expenditures/future encumberments.

Forms and Miscellaneous

1) Complete evaluation of core staff monthly.
2) Complete Clinic preschool evaluation form at the end of the semester.

Responsibilities of the Director of the Clinic for Exceptional Children

Direction

1) Selection of staff members.
2) Making suggestions and decisions regarding preschool policies and commitments.
3) Providing assistance in solving specific problems.
4) Coordinating interaction between the staff members and the Administration and Faculty of the School of Education.

Meetings

1) Attend core staff meetings.
2) Meet with faculty members to disseminate current information on the preschool.

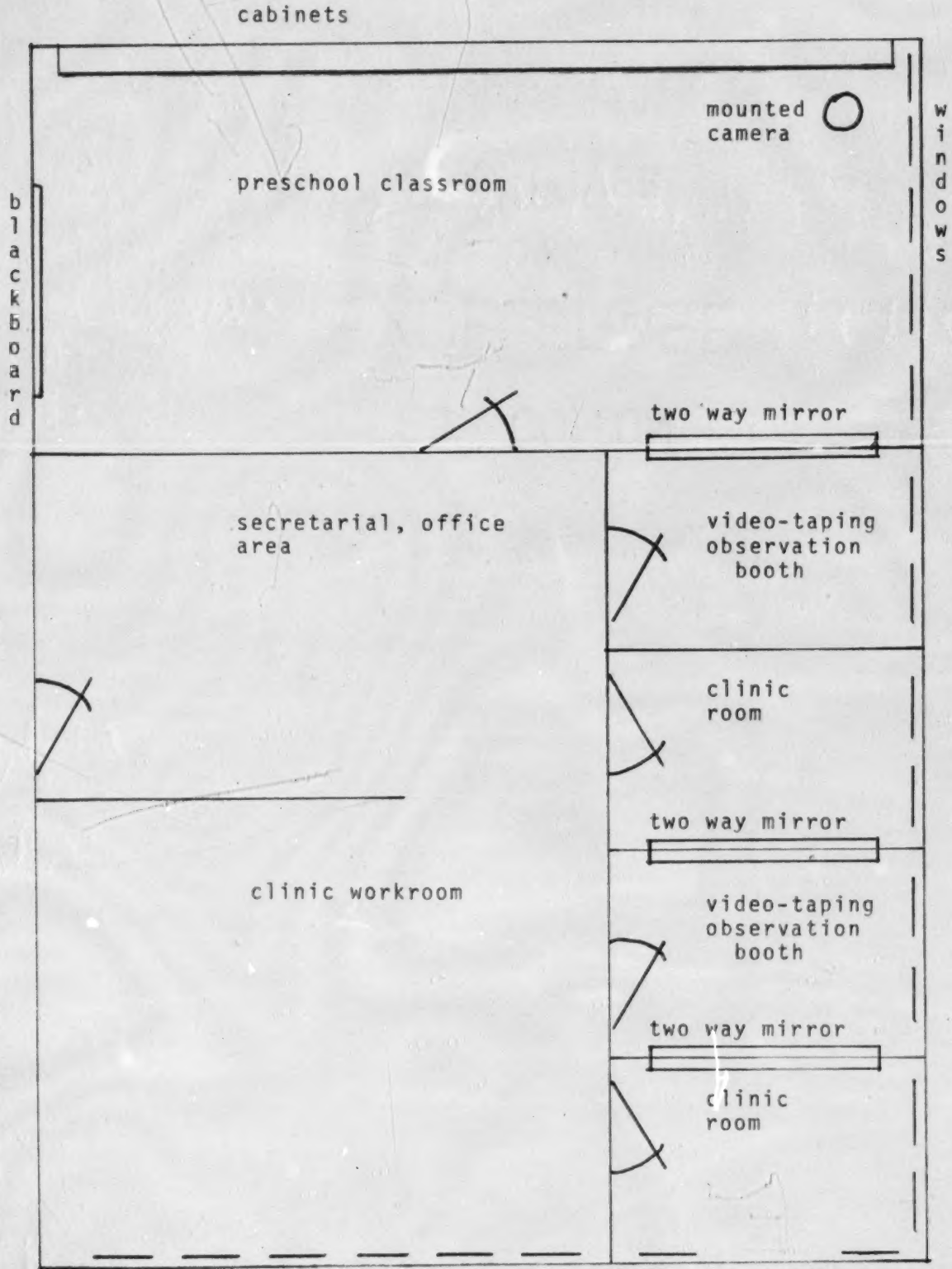
Planning

1) Evaluate continuity and competencies of core staff members throughout the semester.
2) Evaluate suggestions and needs of the preschool as they arise and seek solutions based on those needs.
3) Evaluate and direct policy.

The entire staff will attend weekly preschool staff meetings for the purposes of:

1) Defining goals and terminal objectives in working with the children.
2) Establishing each child's individual curriculum for the following week.
3) Discussing specific techniques and procedures in order to insure consistency in working with the children.
4) Reporting on educational activities of individual staff members which are of interest to the entire preschool.
5) Discussing specific problems which arise in working with either the children or parents.
6) Developing future projections concerning the preschool.
7) Deciding on the scheduling of field visitations.
8) Working out in-staff problems and insuring viable communication.
9) Core staff members can decide when and if other meetings are necessary, and these meetings must be attended by all teachers.

Clinic for Exceptional Children
Preschool Unit Floor Plan, Facilities



Preschool Facility

The Preschool Unit of the Clinic for Exceptional Children is located on the fourth floor of the University of Southern California, School of Education, Waite Phillips Hall. The preschool classroom within the clinic is the area designated for all academic and social interaction situations including receptive and expressive language, cognitive development, self help, and music and art. The preschool uses four small rooms located in the Clinic and four rooms in the Reading Clinic, 6th floor. These rooms are equipped with video tape recorders and one-way mirrors for parent and visitor observation of clinical sessions, testing and time-out procedures. A large open area with a conference table and several chairs is used for staff meetings and parent training classes.

The main preschool room is 19 X 13 with one wall of built-in floor to ceiling cabinets and one wall of windows and has overhead fluorescent lighting. The room can only adequately maintain a group of 8 to 9 children.

The room is arranged for maximum flexibility in reorganization according to the children's individual needs. All furniture is light and mobile and can be rearranged for group or individual sessions.

Curriculum

The Preschool Unit of the Clinic for Exceptional Children provides a language-based curriculum which focuses on the development of pre-academic skills. The general areas of concern include language and cognitive skills, affective development, self-help activities, perceptual-motor development, and creative expression (music and art).

Although the program is of an electic nature, there has been strong reliance on the incorporation of the language paradigm discussed by Myklebust (Johnson and Myklebust, 1967; Johnson, 1968) and Kephart perceptual-motor scheme (Kephart,1968). Within the framework outlines by Myklebust emphasis is placed on the objective of initially helping the child to develop the skills related to inner language. As competency in inner language emerges, instruction related to other dimensions of the language continuum, namely the receptive and expressive components, is included. Perceptual-motor training follows a developmental sequence: motor training, motor perceptual, perceptual motor (differentiation, discrimination), perceptual (integration), perceptual conceptual (function), and conceptual (abstraction, symbolic thinking).

Employing a diagnostic-prescriptive approach, several factors or determinants are considered in the individual curriculum organization. The most important considerations include the child's strengths and weaknesses and the child's level of functioning upon admission to the preschool program. Following is initial assessment of the child's abilities and levels of functioning; the child is then instructed along a competency-based program of sequential development.

U.S.C. Clinic Preschool Objectives

1) To allow the individual child experiences, both individually and in small group settings that will encourage self reliance and independence.
2) To stress the individual strengths and abilities of each child and to minimize areas of weakness and/or disability.

3) To offer parents the opportunity to actively engage in the learning processes of their child and work closely with their primary teacher in developing competency skills in behavior management and pre-academic training.

4) To offer support services to the community and to actively help in determining the future of preschool services to exceptional children in the Los Angeles area.

Identification and Placement Procedures (Preschool)

1) Placement depends upon the proper identification of special needs either conferred through past medical, psychological and educational data available as reference material or through appropriate diagnostics performed prior to placement.

2) In the preschool diagnosis is an attempt to identify any discrepancies between the performance level of the child, his/her chronological age, and to his/her total environment.

3) Heterogeneity within the client population is preferred. For every four exceptional children their should be at least one "normal" child serving as a model for the other children.

4) The staff of the preschool makes an effort to be cognizant of the "Hawthorne effect" during diagnosis and initial remediation. The "Hawthorne effect" refers to a tendency for the subjects behavior (in this case the child's behavior) to temporarily improve because the child is being given attention and is experiencing a new situation.

5) Behavioral alternatives are specified.

6) Placement depends upon 1) the growth available to the child, parent and teacher-trainer, 2) the ecology of the preschool, and 3) individual differences between children maximized through stressing placement dependent upon the severity of the handicap, rather than description or label.

7) Ability to recommend future placement alternatives.

8) Parents contact and make decisions regarding the final placements for their children after careful consideration and knowledge of placement alternatives.

Daily Schedule

The preschool daily schedule delineates time periods for individual and group activities, encompassing language acquisition; cognitive development; appropriate socialization; development of self-help skills; gross and fine motor activities; and play, music and snack sessions.

All unnecessary or distractable items which could interfere with the child's learning or behavior will be kept out of sight. Rather than creating a sterile atmosphere, the room is bright and is conducive to working for both teachers and children. All materials are located at the children's level to encourage independence and self-reliance in choosing and putting away materials. Items for juice time, such as cups, napkins, juice and crackers, are all at the children's level to encourage their participation in setting the table, serving and cleaning up.

A kitchen timer is used to designate the end of each task session. The children's toilet needs are attended to by the parents once just before school and by the parent and teacher during school time in accordance with that child's needs.

The session content is varied to meet the critical needs of each child. At 11:00 the children meet as a group for a 15-minute juice time. Items such as crackers with peanut butter they can spread, bananas they can cut, and juice they can pour are served. The children are required to verbalize what they want before they receive it. Every effort is made to get the children to make demands upon their environment. For the non-verbal [illegible] of verbal apprizimation is reinforced. The children are encouraged to speak and interact with the teachers and the other children. Each child cleans his place, throws away his paper cup and napkin and joins his teacher for the 15-minute period on Concept Development. Each child's conceptual task is prescribed according to his individual learning needs.

Rules and Regulations

1) Teachers must be in the Clinic from 9:15 to 9:30 to set up activities for the day.
2) Teachers and core staff must be ready to start no later than 9:30 a.m.
3) Teachers are responsible for cleaning and maintenance of the preschool at the end of the day (around 12:30).
4) No smoking in the Clinic from 9:30 - 1:00, Monday - Thursday--times when children are in the Clinic.
5) Teachers or other staff members that borrow materials, books, testing supplies, etc., must be checked out by the secretary or Supervisor.
6) Typing requests must be submitted to the Coordinator and should pertain only to Clinic business.
7) All expenditures must be submitted with a receipt, if possible, to the coordinator.

8) Xerox request must pertain to Clinic business.

9) Use of the telephone must be limited to Clinic business.

10) Do not share confidential information about the Clinic preschool population unless cleared by a core staff member.

11) Teachers must notify the supervisor or clinic the day before an expected absence if possible. Otherwise, phone the Clinic by 9:15 a.m. the day of the absence.

12) Teachers are to record each day all behaviors observed in the teaching sessions - using appropriate daily progress forms.

DAILY SCHEDULE

9:30 - 9:40	Greeting - all children grouped in large room. (Songs, learning name, orientation period, etc.)
9:40 - 10:10	Language - Auditory, Inner, Receptive, Expressive (Individual Sessions) Cognitive
10:10 - 10:25	Play period and toilet Entire Group
10:25 - 10:55	Cognitive Development (Visual perception, discrimination skills, categorization, numerical activities, memory skills, comprehension, etc.) Group to be determined by level of functioning.
10:55 - 11:15	Snack
11:15 - 11:45	Gross Motor
11:45 - 12:05	Self-help Skills and/or cognitive Several groups if possible or individual sessions.
12:05 - 12:30	Art and/or Music

Contingency Management

Contingency management or behavior modification methodologies will be used in the preschool as a means to shape appropriate behaviors, estinguish inappropriate behaviors and maintain or expand existing appropriate behaviors and maintain or expand existing appropriate behaviors in children. Methods used will vary with the individual children and will be evaluated and modified weekly according to the children's progress and needs. Positive reinforcement for appropriate responses will be stressed. Also substitution of alternative appropriate behaviors for unappropriate behaviors being extinguished will be employed.

Prior to the establishment of individual behavior modification programs, baseline data should be taken on each child and the target behaviors which are to be modified, increased or extinguished. Initial assessment of the individual child's developmental level of functioning will occur prior to interventions. Assessment will include both formal and informal methodologies.

Following the collection of baseline data, contingency management programs will be established for each child on various behaviors. The behaviors to be changed and the techniques used will be decided on during team and staff meetings.

A wide variety of procedures have been employed in various behavior modification programs. Methodologies utilized in this program will be individualized and based on the specific child's needs. Possible methods to be used will be positive primary reinforcement for appropriate responses in the form of food; positive secondary reinforcement including verbal praise and physical contact between the teacher and child such as hugging

or tickling, tokens or checks to be exchanged for specific privileges such as additional playtime or the purchasing of a small toy or cookie; shaping procedures in which gradual successive approximations to a behavior are reinforced; modeling; substitution of alternate appropriate behaviors for inappropriate behaviors; active and passive ignoral of inappropriate behaviors as methods of extinguishing them, active ignoral involving turning away from the child when an inappropriate behavior is exhibited and only turning back to the child 15-30 seconds after this inappropriate behavior has ceased, passive ignoral involves paying no attention to the inappropriate behavior but merely continuing with whatever activity is occurring as if the inappropriate behavior had not occurred at all; verbal aversives such as "no"; time-out in which upon the child exhibiting an inappropriate behavior the child is told "no" and is immediately seated in the nearest corner in a chair. The child remains in time-out for 30 seconds after the inappropriate behavior has ceased. If the child is engaged in further inappropriate behaviors while in time-out, he/she remains in time-out for 30 seconds after these behaviors have ceased. This 30 second waiting period is to insure that the child is not rewarded, by being removed from time-out, for inappropriate behaviors. Should tantrumming occur while the child is in time-out, the child can be restrained in the chair so that he/she will not be physically endangered by falling. Attention given to the child during this procedure should be kept to a minimum so that the child is not being reinforced for this behavior. Verbal interaction between teacher and child during time-out should also be kept to a minimum so that the child is not being reinforced for this behavior. Verbal interaction between teacher and child during time-out should be limited to prompts such as "when you are quiet we can

go back and work." Verbal interaction of this type should be used only if the child is in time-out for over 2 minutes and does not seem to be quieting down or stopping the inappropriate behavior.

Inappropriate and appropriate behaviors for each individual child will be determined in team and staff meetings. The primary teacher for each child will be responsible for recording these behaviors and contingent interventions for their primary child/children. These written records of interventions will then be kept in the preschool in folders for each child and will thereby be readily available for the teachers to acquaint themselves with. All teachers in the preschool will be responsible for being familiar with the behavioral intervention programs on each child in an attempt to maintain consistency in interactions with the children. This consistency is possibly the most important factor in the program as it can help the children understand what is expected of them and what types of interactions they can expect.

Observation and Recording

Psychological test scores may not be valid with children whose expressive and receptive language capacities are either impaired or not sufficiently developed due to maturational lag. Severly handicapped children rarely have receptive language abilities which allow them to understand the verbal instructions of a test. And in those tests which require an expressive verbal language, the deficiency is even more apparent. In those cases in which a test is administered, the directions on presentation of the test items have been modified so as to make the resulting score invalid.

If the test scores from formal diagnostic and assessment instruments about a particular child are to be of value to the preschool teacher, they must first be valid and secondly, provide specific details about the child's academic and social behaviors. To date measurement and evaluation in education have described individuals within groups and their relative standings between groups, (Kunzelman, 1970, Kirk, 1964). Useful information for the educator would be that which describes intra-individual differences.

Behavioral observations in both a naturalistic and a relatively restricted environment can provide the educator with detailed descriptions of on-going behavior about a particular child. The observation instruments used to collect the data can be designed to focus on the specificity of behaviors or more general categories of behaviors. Therefore, behavioral data can provide the educator with specific information about inter- and intra-individual differences. An educational system based on specific performance data can be sensitive to individual differences. A system which employs continual assessment provides information on detailed behavioral changes which are important in the evaluation of an educational program. This information can be used as a basis from which to make decisions regarding: terminal and enroute objectives, the appropriateness of the materials used, the use of specific behavioral techniques and procedures, and the validity of criterion levels. On-going assessment is most sensible when it is considered as an integrated and useful component of a program. Evaluation can be a useful program tool to those educators interested in consistency, effectiveness and continual improvement of their efforts through a decision-making model. (Gallagher, 1973.)

Behavioral observation techniques are used in the preschool to provide information about the children's performance. Observation data is collected from both unstructured and structured settings. In the unstructured setting the children without adult supervision were observed from the observation room. This setting provided information about a child's interest, attention span, interaction with peers, social abilities, and child movement.

Performance data about specific abilities is observed and recorded during structured settings. The environment is restricted to reduce the number of variables. Structured settings involve directed lessons on a one-to-one or small-group basis. These directed lessons are specific for each child.

Pre-entrance data on functioning levels for individual children are recorded over five consecutive sessions. The data which should be collected/recorded includes verbalizations, attention to task, peer interaction, fine and gross motor abilities, and perceptual-motor skills, self-help and language patterns. Direct observation video tapes and anecdotal records serve as a source of data needed to develop a program of instruction for each child based on inter- and intra-individual abilities.

INTRODUCTION TO PARENT TRAINING

Since the mid sixties there has been an unprecedented demand by both parents and educators to identify and educate children with handicaps as early as possible. The efforts of such programs as Head Start and the National Laboratory on Early Childhood have informed the professional and lay public regarding the capacity of young children to learn and regarding the need of early learning experiences for the full development of the child's potentials. Such efforts are now becoming realized by educators such as Merle Karnes who states that "...administrators of special education are beginning to reorder their priorities and allocate large proportions of the funds available to them to the identification of an early programming for young handicapped children. They are beginning to more fully recognize that the young years are the 'payoff' years" (1973:XIV). In recent years there has been growing belief among those committed to early education of children that appropriate instruction in the early years will result in the child functioning at a higher level both educationally and socially.

In accordance with the demand for early education, many programs have been initiated under the premise that handicapped and non-handicapped children were not necessarily best served in segregated programs. Dunn presents the philosophy of many current educators when he states, "Much of our past and present practices are educationally wrong. We have been generally ill-prepared and ineffective in educating these children. Let us stop expanding a special education program that we know to be undesirable for many of the children we are dedicated to serve" (1968:5). Dunn's contention is that the categorizing of people and of programs creates several problems. The tendency to assign stereo-typed

characteristics of a group to individuals is frequently in error and often prejudicial to the interests of the individual. Labeling of children often creates stigmas which may eventually develop into self-fulfilling prophesies of inadequacy. Too often categorization implies educational treatment based upon the characteristics of the category rather than upon the unique educational needs of the child. Christoplos and Renz contend that "...if clearly beneficial objectives, unique for a particular exceptionality, cannot be identified, then the exceptional group in question should not be segregated from normal society" (1969:375).

In the many proposals for Early Intervention programs, the Bureau of Education for the Handicapped has encouraged the use of a variety of systems for delivery of services to the young handicapped child. Accordingly, one of the latest innovations has been the involvement of parents in the educational programs of their children. The results of recent programs utilizing parent participation indicates many benefits for both parent and child. Barsch (1969) has commented that no parent is ever prepared to be the parent of a handicapped child. Further, they are equally unprepared to undertake their children's education either unassisted or with only sporadic professional assistance. Assuming that parents are one of the most influential educators of their child, systematic training in the parents' ability to promote the child's social, cognitive, and emotional development maximizes their effectiveness as teachers. Furthermore, in addition to the benefits derived by both parent and child, the effectiveness of the entire educational program is enhanced by the unique skills and knowledge contributed by the parent.

In response to the demands for early intervention, non-categorical programs, and parent training and educational involvement, graduate students and faculty at the University of Southern California initiated a preschool program in the Clinic for Exceptional Children. This monograph is a report of the results of the first four years of this program. In addition, this monograph has been designed as a training manual for teachers and parents in a non-categorical model preschool program.

The potential of parents as positive, educational facilitators has only recently been recognized. In the past, most parent participation programs utilized parents simply as teacher aides who did not assume instructional responsibilities. In contrast to similar programs, one of the primary concerns of the preschool unit program is to train parents as paraprofessionals, thus enabling them to be a viable force in the educational development of their children. As Kroth pointed out: "Teachers and parents who come together to share information may find that a problem exists which can best be resolved by mutual action." The second objective is to facilitate parents in the acquisition of a positive first experience with school. Finally, through interaction with their children in the classroom, and with the other parents, they can more fully understand their child as a unique individual with his own strengths and weaknesses.

The parent participation program in the preschool will focus on the following competencies:

1) To provide parents with the skills and abilities necessary to implement behavior modification techniques in the home and classroom.

2) To work with parents toward developing a suitable curriculum for their children.
   a. To make parents aware of developmental levels and critical periods in the acquisition of learning abilities.
   b. To provide parents with the opportunity to construct appropriate learning materials in the classroom.
   c. To counsel parents in methods to continue existing instructional programs from the preschool to the home.
   d. To familiarize parents with educational resources and facilities.
3) To enable parents to develop teaching competencies within the classroom and to demonstrate these competencies in working with children other than their own.
4) To inform parents of continuing educational programs that would benefit their child.
5) To formulate with parents realistic goals and future projections on their child's potential abilities.

To insure that parents fully participated as staff members, it is necessary to establish definite channels of communication. Two means of effective communication are established through parent-teacher meetings and written reports. Formal parent-teacher conferences were held each week--1) to discuss the progress of each child, 2) to describe materials that were being used, 3) to discuss immediate and future goals for the child, 4) to suggest possible teaching strategies to be implemented at home, and 5) to discuss educational resources and future placements. In addition to these conferences, individual case notebooks containing

anecdotal records, progress reports and lesson plans are accessible to the parents at any time. Parents are responsible for completing written monthly progress reports which briefly describe any special activities at home and/or specific at-home changes in their child's behavior.

Parent participation in the preschool program will consist of three phases. In Phase I, the objective is to teach parents behavior modification techniques to be used at home and in the preschool classroom. In Phase II, parents are introduced into the classroom during non-academic sessions and have the opportunity to begin applying behavior techniques in small groups with guidance. In Phase III, parent involvement is extended from participation in group activities to formal one-to-one academic teaching situations.

Phase I

The parents observe their children in the classroom and participate in an intensive behavior management class. Training materials for the parent class consisted of Becker's, Parents are Teachers and Paterson and Paterson's, Living with Children. Films and other supplemental materials are presented concurrently. The class sessions cover basic information in behavior management techniques such as methods of pinpointing behaviors, counting behaviors, graphing data, reinforcement techniques, punishment and time-out procedures, shaping techniques and task analysis. Homework assignments include readings, listing behaviors of their children to be accelerated or decelerated, recording behaviors at home, analyzing antecedent and consequent events, assessing reinforcers in their children's environment and applying behavior shaping techniques. Parent class

time also consist of actual practice in utilizing some of these behavior modification techniques with guidance, such as behavior recording, timing-out children and analyzing teacher-child interaction with respect to techniques discussed in class.

Phase II

Parents will spend part of their classroom observation time focusing on specific behavior of individual children inside the preschool. With the guidance of the parent trainers and teachers, parents will participate in non-academic sessions such as opening and closing activities, music, art and nutrition. During these class periods the parents will be able to apply the behavior modification techniques which they have learned in the first phase of the project. (Parent-teacher competencies in this area, as well as other aspects of classroom abilities, are analyzed through discussions with the parent coordinators, video-tape recordings, and conferences with classroom teachers.)

Phase III

(The last part of the parent-training project will phase in parents as behavior recorders and teachers during the three academic periods of the day.) Each parent will begin as a data collector for each period, under the guidance of the classroom teacher and parent trainer. As each parent becomes familiar with the teaching methods involved in the lessons, they assume responsibility for teaching the lesson, at first with and then without supervision. Thus, the parents become equal members of the teaching staff. At this time parents are responsible for planning and teaching the opening, music and selected academic lessons. Time spent

out of the classroom will be utilized for working on parent made educational materials designed by the teachers and evaluating parent participation within the classroom.

Future Projections

1) Begin behavior modification classes several weeks before the preschool opens so that parents will have the competencies necessary for them to participate in non-academic classroom activities from the first day of school.
2) Institute home visits.
3) Institution of the Parent/Child Toy Lending Library Program.
4) Terminal objectives should be stated for the competencies parents should exhibit after parent training classes such as:
   a. Parents will be able to successfully apply general behavior modification techniques like reinforcement, time-out, shaping procedures within the classroom.
   b. Parents will be able to construct appropriate learning materials for use in the classroom.
   c. Parents will be able to teach lessons within the classroom on a one-to-one basis with any of the preschool children.
   d. Parents will actively participate in group lessons such as opening, music, nutrition, and closing.

University of Southern California
Clinic for Exceptional Children Preschool Report

Name: Rachel E.
Birthdate: 11-13-72
Dates in Program: October, 1975, to present (January, 1976)

Description:

Rachel is a small, adorable three-year-old Black female. She has been attending the U.S.C. Preschool since October, 1975, on a four day per week, two hour per day basis. Rachel appears to be a normal child, and her development seems normal in most areas except for language.

Rachel has been in a one-to-one teaching situation for most of her academic sessions which include mainly pre-verbal and attentive activities in which she earns food reinforcers paired with social praise for appropriate responses.

Levels of Functioning:

Gross Motor: Rachel walks with a normal gait and loves to run. In fact, she is rather quick. She can climb and descend stairs using alternating feet and is able to throw and catch a ball using both hands, and can ride a tricycle.

Fine Motor: Rachel can string beads, scribble with chalk, crayon, or pencil, imitate drawing a straight line, and can approximate drawing a circle imitatively. She enjoys working with simple interlocking puzzles, up to about six pieces. She is able to successfully manipulate geometric objects in a form box. She can build a tower with blocks, and can paint with a brush. She can apply glue to paper, and can strike a large target with a hammer.

Language and Cognitive: Rachel has been non-verbal since the age of about sixteen months. Although she babbles frequently and seems to make some attempts at communication through babbling, particularly to show anger, joy and to express desires, Rachel has no understandable expressive vocabulary. She has, on occasion, just recently begun to repeat the words "mama" and "ball" after much prompting, but does not use these words spontaneously. According to the Mecham Verbal Language Development Scale, Rachel is functioning at about the one-year age.

It is difficult to measure Rachel's receptive language since she is highly manipulative and will frequently not pay any attention to your verbal requests. Visual prompts usually help Rachel respond to verbal requests. She has, on occasion, demonstrated understanding of the prepositions in and on, and responds to "give me the ..." if your hand is extended. It is suspected that Rachel may have a hearing problem and a hearing test at the John Tracy Clinic is being planned for the near future.

Personal-Social: Rachel is an extremely manipulative child, and often exhibits oppositional behavior. Because of these manipulative behaviors, it is difficult to measure some of her skills. She functions well in a one-to-one setting, but needs to work in an isolated area because she is very highly distractable. Her "in seat" attention span is about fifteen to twenty minutes, but she particularly enjoys out-of-seat activities such as writing on the chalkboard and making faces and babbling in the mirror. Rachel enjoys playing with toys, especially if someone else has the toy first. She will play with other children on such things as the two-person rocker. She is, however, very possessive of her toys and will scream and fight with anyone who tries to take a toy away from her. She will also take toys from other children.

Summary and Recommendations:

Rachel needs to work in an undisturbed setting during academic sessions. She needs to work on playing cooperatively with other children and on sharing.

Although Rachel is strong in motor skills and appears to be an inquisitive and intelligent child, she is functioning below her age level in language and needs to work on producing sounds and words imitatively. Receptively, visual prompts help Rachel respond to verbal demands, and the upcoming hearing test results may explain this.

University of Southern California
Clinic for Exceptional Children Preschool Report

Name: Johnny R.
Birthdate: 3-25-73
Dates in Program: December, 1975, (continuing)

Description:

Johnny is a 2½ year old white male, diagnosed as Down's Syndrome. Johnny has only been in the pre-school program for three weeks. He attends on a three day per week basis for two hours per day. Prior to this, Johnny attended Kennedy Nursery School in Los Angeles.

Upon admission to the program, Johnny's major problems appeared to be in the area of language. Receptively, Johnny appears to understand simple commands and questions by his behaviors. However, expressively Johnny is functioning at a lower level.

Johnny has been in a one-to-one teaching situation for two twenty minute sessions per day. The first session involves receptive language tasks, while the second one involves verbal tasks. Johnny is also involved in a group session during snacktime and playtime which he responds well to.

Levels of Functioning:

Gross Motor: Johnny can walk with a normal gait and run unaided. He appears to be in good physical health and excellent size, looking more like a boy one year older than he is.

Fine Motor: Johnny can put together a one piece puzzle successfully. Johnny needs more work in areas such as coloring or scribbling with a crayon, building a tower, stringing beads, or glueing objects on paper.

Language and Cognitive: Johnny scored a language age equivalent of 1.90 year level. Based on an interview with Johnny's mother, Johnny has an expressive vocabulary of approximately one hundred words. In the clinic, Johnny has spontaneously verbalized the words mama, daddy, hi, bye, and doggie, and has also verbalized numerous nouns on demand. Johnny can recognize names of familiar objects such as a cup, spoon, car, etc., as well as use their names. Johnny is also able to name common pictures such as ball, dog, cup from the Peabody Language Kit #P. Johnny can also identify his own body parts and name them such as nose, eyes, hair, ears, and head. Johnny is also able to imitate his teacher's lip movements.

In the area of cognition, Johnny is able to successfully perform such tasks as matching colored objects to pictures in red and blue. Johnny uses cognitive skills to manipulate a square, circle, or triangle into a five piece form box. He is also beginning to understand the concept of mine/yours.

Personal-Social: Upon admission to the program, Johnny spent the entire first week crying and whining for his mother during the entire sessions and snacktime. After the first week, however, Johnny began to adapt to his teacher and the surroundings and, as a result, his attention level rose and he stopped crying.

Johnny will now sit appropriately at the snack table and imitate hand raising for a snack. He is also becoming more aware of the other children during playtime, passively interacting with them.

During academic session, Johnny sometimes displays a low attention span and will become oppositional and play with objects or throw them on the floor. At other times, Johnny may become frustrated with the task and begin to whine or cry.

Much of these problems can be avoided, however, if the academic task is varied frequently and kept at a level that will maintain Johnny's motivation to work.

Johnny is reinforced with social praise coupled with a tickle or a hug contingent on correct responding. Since this has proven to be effective, no primary reinforcers are being administered.

Summary and Recommendations:

Although Johnny has been in the clinic for only a short while, minimal gains have been made in the areas of language and cognition as well as social and behavioral. It is recommended that Johnny be continued in the clinic pre-school program on the same program presently designed for him, on a one-to-one teaching basis.

Johnny is functioning at approximately an 18 to 21 month level. His major deficits are in the area of fine motor skills and expressive language, while his major strengths are in the area of cognitive skills and receptive language.

University of Southern California
Clinic for Exceptional Children Preschool Report

Name: Ernestine G.
Birthdate: 6-19-70
Dates in Program: October, 1975 to January 5, 1976 (continuing)
Evaluation Date: 1-5-76

Description:

Ernestine is a five-year-old Black female. She has attended the U.S.C. Preschool for Exceptional Children since October, 1975, on a four-day per week, two-hour per day basis. Presenting problems upon admission were lack of appropriate speech and language, minimal social interactions with both peers and adults, and minimal eye contact.

Levels of Functioning:

Gross Motor: Ernestine walks with a normal gait, is able to run, and can climb and descend stairs using alternating feet while using the handrail. Earnestine is also able to throw and kick a ball, and can ride a tricycle.

Fine Motor: Ernestine can string beads and can button buttons with minimal help. She is able to build a tower of six blocks and a train of four blocks with a chimney.

Matches: Ernestine has difficulty matching primary shapes and colors. She can match objects to objects.

Language and Cognitive: Upon admission to the program, Ernestine did not emit any appropriate speech. According to her mother, she can identify and say the name of her body parts, and can label familiar objects in the environment at home. But it took time for her to say some words spontaneously such as "car," "shoe," "hair," "eye," "cup," "ball," and so on. She is sometimes able to say "my pants" or "my doll", etc. She does not seem to understand the concept of mine/yours. On occasion, Ernestine does spontaneously say a word, however, her expressive language is primarily limited to structured situations and in response to a request presented verbally by the teacher. Most of her words are nouns and she does have difficulty using more than two words in a sentence.

Receptively, Ernestine appropriately responds to simple one and two step directions. She can apply the concepts of come/go, yes/no and give/take.

Ernestine is not able to count. She cannot read or write numerals or letters.

Social: Ernestine is very shy of strangers. She displays very little direct eye contact with an adult whom she is not familiar. Ernestine works well in a one-to-one situation. Ernestine does not usually initiate interactions but will request a hug from an adult with whom she is familiar. Ernestine is increasingly having interaction with preschool teachers and sometimes behaves to try to catch the teacher's attention when she works with another child.

She is beginning to participate in play activities, particularly when playing with balls or blocks, more spontaneously and actively than before.

Summary and Recommendations:

Ernestine is functioning at approximately a 18 to 36 month level with her main deficits in the areas of concepts and expressive language, and her main strengths in the areas of gross motor, manipulative skills and receptive language.

Ernestine needs a language training program in a structured setting in which contingencies and reinforcements are explicit. A constant one-to-one situation with the same adult would be most effective to develop her academic skills; but small group settings would be conducive to her social skills.

University of Southern California
Clinic for Exceptional Children Preschool Report

Name: Danny W.
Birthdate: 8-22-70
Dates in Program: November, 1974 to May 26, 1975
October, 1975 to January, 1976 (continuing)

Description:

Danny is an attractive five-year-old Black male. He attended the U.S.C. Preschool in 1974 on a four-day per week, two-hour per day basis. Since October, 1975, he has attended on a four-day per week, three-hour per day basis. Presenting problems upon admission were lack of appropriate speech and language, inappropriate and minimal social interactions with both peers and adults, minimal eye contact, and lack of play skills.

Danny has been in a one-to-one teaching situation, along with some small group activities, in which he earns social reinforcement for appropriate speech and responses.

Levels of Functioning:

Gross Motor: Danny walks with a normal gait, is able to run, and can climb and descend stairs using alternating feet. Danny is also able to throw and catch a ball using both hands, can ride a tricycle, can climb a ladder and descend on a slide, and is learning to use his legs to pump himself with on a swing.

Fine Motor: Danny can string beads, draw in between two lines, draw a triangle, circle and square using templates, and can complete a ten-piece interlocking puzzle. He is quite adept on puzzles. He is able to successfully manipulate geometric objects in a five piece form box. He is also able to build a tower, train, bridge and pyramid using five colored blocks and can imitatively build a train and tower of five blocks in specific color patterns. He can build a tower of four blocks imitatively from memory and can also build a three-piece gate imitatively from memory. Danny can cut with scissors if someone helps to hold the paper taut. He can spell his name orally and also write the capital letters for his name.

Language and Cognitive: Upon admission to the program, Danny emitted unintelligible sounds but no appropriate language. He is now able to speak appropriately in four and five word phrases and can label familiar objects in the environment; and objects, animals, actions of people, food, clothing, and toys from the Peabody Language Development Kits, Preschool Level.

He can also classify these cards by putting them into appropriate groupings. Danny can verbalize concepts such as big/little, long/short, colors, body parts (discrimination and labeling). He continues to have difficulty with the concepts of mine/yours. On occasion, Danny does spontaneously use expressive language, however, his expressive language is primarily limited to structured situations and in response to a question presented verbally by the teacher. Spontaneous verbalizations are also primarily limited to expressing needs such as "I want a cookie," or "I want a tickle." Danny is now participating in singing during music sessions and will ask for food during snack sessions. He still uses some echolalic language and his syntax is not up to age level.

Receptively, Danny appropriately responds to simple one and two step directions. He can apply the concepts of big/little, in/on, long/short, come/go, yes/no, and give/take. His behaviors indicate that he understands much of what is said to him. He can follow directions to "Put the block on Danny's nose," "Put the block on teacher's nose," but cannot follow directions to "Put the block on your nose," "Put the block on my nose." He can do "next to" and "under" only imitatively.

Danny can count by rote to twenty, and with few mistakes to thirty. He can read numerals to four, can match quantity to numerals (to four), and can match pictorial quantity to numerals (to four).

Personal-Social: Danny is occasionally oppositional or testing, particularly when working with an adult with whom he is not familiar and sometimes even with adults with whom he is familiar. Danny works well in a one-to-one situation and has become more responsive to attention from both adults and peers. He has recently initiated contact with his regular teacher by going up to her, holding out his hand and saying, "Danny, Danny" or "Work!" He is becoming increasingly possessive and jealous of his teacher's attentions especially during group sessions or if that teacher is involved with another child. He has also been imitating inappropriate behaviors of other children and looking around until he gets the attention of his own teacher. Danny seems to be increasingly enjoying interactions involving physical interaction, such as tickling and hugging; responding by smiling and laughing. He will also participate in play activities such as playing ball, if this is initiated by another individual.

Danny tends to perseverate in some play activities, particularly when playing with toys such as cars or trains. This play behavior sometimes takes the form of inappropriate self-stimulatory behavior (such as spinning the blades on the helicopter or turning the siren on the play village fire-house.

Summary and Recommendations:

Danny needs a highly structured setting in which contingencies and reinforcements are explicit and consistently enforced. Individual attention along with small group settings continue to be most conducive to his learning. He evidences a wide range in skills and behaviors with his main deficits in the areas of socialization and expressive language, and his main strengths in the areas of manipulative skills and receptive language. Although Danny does have many skills, he does not exhibit all of these consistently due to oppositional and testing behaviors.

University of Southern California
Clinic for Exceptional Children Preschool Report

Name: Frankie N.
Birthdate: 5-22-70
Dates in Program: 6-1-75 through 1-13-76

Description:

Frankie is a handsome five-year-old male of Spanish descent. He has attended the University of Southern California Preschool since the summer of 1975 on a four day a week, four hours a day basis. Upon admission to the program Frankie's outstanding problems included a lack of appropriate speech and language, bizarre self-stimulatory behaviors, inappropriate social interaction with peers and adults, and poor eye contact.

Frankie was involved in a one-to-one teaching situation. Appropriate behavior was rewarded with reinforcements consisting of food or water paired with social praise. (Self-stimulatory behavior resulted in the reprimand "No Frankie, hands on the table". Effort was made to administer intermittent reinforcement when his hands were placed palms down on the table.)

Levels of Functioning:

Gross Motor: Frankie demonstrates coordination and precision in large muscle movement. He walks with a normal rhythmic gait, and can run and jump. When given the command, "Frankie, push the ball", he will roll the ball on the floor to a receiver. He is also capable upon repeated requests to throw and catch a large ball with both hands. When his feet are placed on the pedals of a tricycle, Frankie will ride.

Fine Motor: Frankie is capable of scribbling on command and correctly placing geometric blocks in a form box. He is able to complete ten piece interlocking puzzles, can imitatively build a tower of five colored blocks, and insert and remove pegs in a pegboard.

Language and Cognitive: Upon admittance to the clinic Frankie emitted no appropriate speech or language. Occasional perseverated garbled noise was the only sound verbalized. At the present time Frankie is able to inconsistently imitate an "m" and "b" phoneme and has increased the length and frequency of babbling. The words "mama", "papa" and "baby" were the words which brought recognition from Frankie and served as motivators for imitation of appropriate sounds.

Receptively, Frankie responds to one step directions such as "Give me", "Sit up/down" and "Put in". He is able to hand an object to the teacher upon request but random selection of an item occurs when two or more items appear. Concepts of color, size and number are at present undistinguishable to Frankie.

Personal-Social: Frankie works well in a one-to-one teaching situation until his frustration level has been reached. When this occurs, he tends to tantrum and attempts to run interaction with others. For the first time he is aware of the presence of other children and attempts to touch them on occasion. A bond developed between Frankie and his teacher resulting in jealousy displayed by Frankie when he felt he was being ignored. Frankie's response to tickling and smiling has increased and he seems to be enjoying it more.

During playtime Frankie still requires constant attention, for without it he will engage in self-stimulatory behavior. This behavior usually takes the form of tapping on any object available for extended periods of time.

Summary and Recommendations:

It is mandatory that Frankie receive continued instruction in a stimulus-free environment on a one-to-one basis. Continued reinforcement for behavior incompatible with self-stimulatory actions is necessary to increase eye contact and on task behavior.

Frankie's major deficits lie in the area of receptive and expressive language with his strengths in the areas of gross and fine motor skills. Progress has been made but continued repetition is advised for retention.

University of Southern California
Clinic for Exceptional Children

Name: Jennifer P.
Birthdate: 12-27-71
Dates in Program: 10-1-75 - 12-17-75 (continuing)
Date of Evaluation: 12-17-75

Description:

Jennifer has a tentative diagnosis of cerebral gigantism. As per the diagnosis, she appears to function in the severe level of mental retardation and exhibits autistic-like symptoms. These include hand-waving, rocking while standing, and hand-biting in which the skin is sometimes broken. Jennifer is a tall, attractive child. Her head is larger than the norm, ranking in the 90th percentile, also characteristic of cerebral gigantism.

Presenting problems upon admission to the clinic were lack of speech as well as limited receptive language, minimal social interactions, and lack of play skills.

Jennifer has been in a one-to-one teaching situation as well as being involved in structured and unstructured small group activities. Jennifer earns both primary and social reinforcement for appropriate behavior and academic progress.

Levels of Functioning:

Gross Motor: Jennifer walks with a normal gait. She is capable of running, hopping, and jumping, but because of her detachment, is less likely to exhibit these behaviors. She is capable of throwing a ball, but will not attempt to catch. She is learning to push a ball or car. Jennifer enjoys sitting in the rocking boat. She shows no interest in riding the tricycle. Jennifer has some success, although limited, in imitating gross movements.

Fine Motor: Jennifer began with no imitative behavior and has learned fine motor activities through shaping procedures. She can push large blocks with holes onto a wooden cylinder non-imitatively. She will also replace cylindrical blocks of various sizes into their appropriate compartments. She can build a tower of four blocks imitatively. She is partially successful in manipulating various geometric objects in a five piece form box. Jennifer will hold a crayon but will not scribble. She requires assistance in painting and gluing activities and will attempt to eat these and other art materials. She is not able to use training scissors.

Language and Cognitive: Jennifer's language skills are at the one year level as tested by the Mechum Language Scale. Her expressive language is limited to the word "juice" which she uses spontaneously during snack time. Receptively, she can respond appropriately to simple one-step directions. These include give/take, put in, come here, sit down, stand up, and yes/no.

Personal-Social: Since admission to the clinic, Jennifer has increased attending behaviors during both structured academic lessons on a one-to-one basis and group activities. During academic lessons she has increased eye contact and will "look at me" upon command. Jennifer's initial response to instruction was crying and tantruming, which have been greatly reduced. During group activities, Jennifer has increased her eye contact with peers and has begun to interact spontaneously with play objects in the environment.

Jennifer passively enjoys being hugged and held and sometimes will respond to laughing and smiling. She has just begun to initiate this interaction with familiar adults.

Self-help: Jennifer is partially toilet trained; she occasionally wets herself, but will use the toilet when taken to the bathroom. She can pull her pants up and down with limited assistance. She will put on a T-shirt if it has been pulled over her head. She attempts to help put on her shoes and socks. Jennifer will cooperate with someone washing and drying her hands, but will not imitate this behavior on her own. She can drink from a cup and eats with her hands.

Summary and Recommendations:

Since Jennifer joined the Preschool Program, I have observed a definite increase in eye contact, social interaction, imitative behavior, and the willingness to respond to instructions. This has been accompanied by a decrease in manipulative behavior such as tantruming and biting. Her progress is encouraging and she continues to require a highly structured environment of consistent contingencies and reinforcements. Individual attention continues to be necessary to increase her academic skills and social interaction on a one-to-one level; the opportunity to also participate in small groups of peers in structured and unstructured settings will be conducive to increasing play activity, interactions with peers, and the ability to function in a group.

University of Southern California
Clinic for Exceptional Children

Name: Andre L.
Birthdate: 11-8-75
Dates in Program: 11-1-75 - 1-5-76 (continuing)

Description:

Andre is a little boy of four years old. He has attended the U.S.C. Preschool Program since November, 1975, on a three days per week, two hours per day basis. Presenting problems upon admission were lack of appropriate speech and language, developmentally delayed, inappropriate and minimal interaction with both peers and adults, and lack of play skills and self-help skills.

Andre has been in a one-to-one teaching situation, along with some small group activities in which he earns social reinforcement, not primary reinforcers, for appropriate responses.

Gross Motor: Andre walks a normal gait, is able to run and jump. He can throw and push a ball with both hands but cannot catch a ball nicely.

Fine Motor: Andre can complete a four or five pieces interlocking puzzle. He can build a tower and train with four or five blocks. Andre can scribble or draw simple lines with crayons. Also he can string beads well.

Language and Cognitive: Andre is able to speak about a hundred words, refer to his mother. He speaks more when you get acquainted with him. Andre has difficulties in pronouncing some of the consonants and that makes some of the sounds unclear. Andre seldom speaks more than one-word phrases appropriately. He can label familiar objects in the environment, like food, body parts and clothes, but he seldom says the word. Andre does have difficulties in differentiating the concept of long/short, big/small, colors, and numbers.

Receptively, Andre appropriately responds to simple commands and directions. Sometimes he is quite aggressive and oppositional, though he understands much of what is said to him.

Andre is not able to write or read numerals or letters.

Personal - Social: Andre is often oppositional, particularly when working with an unfamiliar person. Also he would whine and cry more at the beginning of each week. Andre usually works well in a one-to-one situation in the latter part of the week, when he feels more familiar with the environment again. Andre does not initiate interactions or play activities with the other children. Moreover, he often hits and pushes other people.

Andre can sit appropriate at snack time and initiate handraising when asking for food. Andre enjoying tickling very much; responding by laughing. Andre's favorite toy is a car. He would neglect everything when playing with cars.

Summary and Recommendations:

Although Andre has been in the clinic for only a short time, minimal gains have been made in areas of language and cognition as well as social and behavior. It is recommended that Andre be continued in the preschool program on a one-to-one teaching basis for further and better improvement.

Andre is functioning at approximately a one- to two-year level with his main deficits in the areas of expressive language and socialization, while his major strengths are in the area of cognitive skills and receptive language. Andre should do better if he pays better attention and is less oppositional.

University of Southern California
Clinic for Exceptional Children

Name: Felicia S.
Birthdate: 7-31-70
Chronological Age: 5-6
Period Covered: 9-75 - 1-76

Language Factors:

Felicia's language functioning is a characerized by deficits in rapid auditory processing, association and conceptual skill, vocabulary usage, syntactical structure and articulation abilities (speech sound production).

Receptively, Felicia has demonstrated improvement in her ability to attend to relevant auditory stimuli on a more consistent level. This improvement has been evidenced by Felicia's improved ability to associate simple ideas presented auditorially and in auditory discrimination skills. Additionally, it has been observed that Felicia is now able to remember and to follow simple two-step commands. However, she continues to experience difficulty in understanding abstract language.

Visual reception performance (i.e. visual attention) is less adequate than auditory performance. Felicia has shown much difficulty in performing visual discrimination skills such as matching like objects. A factor contributing to this deficit may be related to Felicia's inadequate visual acuity. Due to temporary medication (eye drops) prescribed by her physician, Felicia's vision has been reduced in one eye (right) and in the left eye there is limited vision. This information was reported by her mother. Peripheral vision appears to be non-existent.

Integrative language skills and general cognitive functioning are below age level expectancy. To help Felicia to improve these areas focus was placed on the following:

1. Associate Language: Tasks employed included categorization, classifying, vocabulary expansion, numerical understanding (counting), and discrimination. Additionally perceptual skills related to spatial relations (over, under, behind, etc.) were also included. Felicia is able to name and to classify food, clothing, body parts and some common animals. She can identify colors (red, blue, yellow and green) on an inconsistent basis. Felicia has expressed generalized difficulty in performing those activities which require forming relationships, recall, matching, classification, etc. which has resulted in limited progress in general comprehension.

2. Syntactical Structure: Tasks focused on Felicia learning and generalizing the use of present progressive verb forms. A structured programmed learning approach was employed. Generalization has been observed in conversational speech. Felicia continues to present grammatical errors related to plurals, possessives, verb tense, articles and adjectives. Sentence length (assessed informally) has increased from a mean sentence length of 2 words to five words, usually consisting of a simple noun-verb-object pattern.

Articulation is characterized by multiple errors of articulation (omissions, substitutions, and distortions) which are inconsistent in nature. Range and speed of movement of the articulators is limited. Connected speech performance is reminiscent of those speech patterns commonly associated with dysarthria.

Self-Help Factors: Felicia's apparent poor fine and large muscle coordination appears to interfere with her ability to adequately develop certain self-help skills. She is able to take off and put on her own clothes but this is done in a slow and awkward manner. She requires help in buttoning, lacing and tying. She is able to eat independently.

Emotional Factors: Felicia enjoys participating in social activities and has shown measurable improvement in lessening of tantrums and a decrease in using manipulative devices for gaining adult attention. She has ceased to ask "What's that?" when in fact she knows the answer. It appears as her comprehension has improved, Felicia uses more cause-effect understanding in solving her emotional problems.

Gross Motor: Movement has been one of Felicia's most deficit areas of functioning. She is ambulatory but walks and stands in an awkward manner, often holding on to others for support. She characteristically walks on her toes. Felicia is able to independently climb and descend stairs but in a very slow and unbalanced manner. It is necessary for her to place both feet together on a step before proceeding to the next level. She needs to learn to "look ahead" when walking. Improvement has been observed in her walking when she is wearing leg braces.

Summary:

Felicia is functioning approximately two years below age level expectancy in language, articulation, self-help skills and gross motor development. Emotional development appears to be closer to age level expectancy.

Recommendations:

Felicia's future programming should include the following:

1. Continued focus on auditory and visual perception development especially in terms of attention and discrimination.

2. Majority of focus to be placed on integrative language and cognitive skills.

3. Development of suntactical structure to include all parts of speech appropriate for her age.

4. Referral for individual speech and language therapy.

5. Explore the possibility of Felicia receiving individualized physical and occupational therapy outside the pre-school setting.

Implications and Conclusions:

Over the past five years, the Preschool Unit of the Clinic has changed both in emphasis and design. The basic concepts of the non-categorial approach have been expanded to include a wider range of severe behavioral disturbances and even cognitive and developmental ability. The importance of early intervention has significantly reflected itself in the categorial funding offered through various service delivery systems presently providing the Preschool with clients.

Experiences in teacher training have emphasized the importance of task analysis and competency-based instruction. The diagnosis and evaluation of children has replaced traditional, norm-reference tools with criterion-reference programming and client classroom behavioral observation. The utilization of doctoral students as supervisors of teacher training has allowed greater continuity, structure and guidance for the new teacher.

Working closely with the parents has expanded our original parent-training model. Parents now are seen as change agents, equal to the teachers in many of the important skill areas. Parents have effectively learned to reinforce and systematically shape academic skills and behaviors in their children, utilizing identical teacher-training materials. An addition to the on-going training directly within the Preschool, the parents have the option of working with interventionists, that follow-up closely with the child in his natural environment. Numerous research studies within the Preschool have confirmed the effectiveness of parent training, the effects of parents working with children with various types of problems and the adequacy of the teacher-training program within the Preschool.

Ad the population of the Preschool has expanded, the necessity for available space has reflected itself within the program. Future projections call for immediate expansion of the Preschool facility, to accommodate integration of normal preschoolers, and to allow for a wider range of experiences. Research is in preparation to analyze the interaction effects of normal children working and planning alongside other severely handicapped children.

Date: _____

Daily Record

Child's Name _____ Primary Teacher: _____

Teacher Session 1: _____

Reinforcement	Task	Performance	Targets +,-,/
9:30-10:00		Teacher:	
10:20-10:40		Teacher:	
11:20-11:40		Teacher:	
11:45-12:05		Teacher:	

WEEKLY LESSON PLAN

Child _____ Teacher _____ Week _____

Subject _____

OBJECTIVES:

RATIONALE FOR OBJECTIVES:

MATERIALS:

PROCEDURES (TASKS):

REINFORCERS:

CONTINGENCY:

SCHEDULE:

PROGRESS REPORT (Six Weeks)

Child's Name _____ BD _____ CA _____

Teacher _____

Period Covered _____

This report should be brief with only pertinent data included. The data should consist of an objective summary (avoid the use of subjective impressions except where indicated) of tasks presented and the child's responses.

LANGUAGE AND COGNITIVE FACTORS:

PERCEPTUAL MOTOR DEVELOPMENT:

EMOTIONAL-BEHAVIORAL FACTORS:

SELF-HELP SKILLS:

RECOMMENDATIONS AND IMPRESSIONS:

LONG-RANGE OBJECTIVES

Child's Name:

Birthdate:

Teacher:

Date:

Anticipated Period (Weeks):

Language and Cognition:

Emotional Behavior:

Perceptual-Motor:

Self-Help Skills:

Report Writing Guide

(End of Semester Developmental Profile Report)

I. IDENTIFICATION DATA

Child's Name
Birthdate
Age
Sex
Parents' or Guardians' name
Teacher's name
Period Covered

II. PERTINENT MEDICAL INFORMATION

III. LANGUAGE AND COGNITIVE FACTORS

Comprehension

Listening
Attentiveness
Identification abilities
Discrimination abilities
Peripheral functions (Auditory and/or visual acuity)

Integration

Perceptual accuracy
Memory-association
Memory-recall (both immediate and delayed)
Verbal Comprehension

Expression

Articulation

General intelligibility of spontaneous speech
Identification of articulatory errors, i.e., omissions, substitutions, or distortions

Description of quality and quantity of expression. Include linguistic performance.

IV. SENSORY-MOTOR-PERCEPTUAL FACTORS

Auditory awareness
Auditory attention
Auditory memory
Auditory identification
Auditory discrimination

Report Writing Guide (Cont'd.)

Visual discrimination
Visual memory
Visual-motor function
Color discrimination
Gross motor functions
Fine motor functions (e.g., finger skills, eye-hand coordination)
Laterality
Spatial relations
Spatial orientation

V. SELF-HELP SKILLS

Toilet
Dressing
Health habits
Eating habits

VI. EMOTIONAL-BEHAVIORAL DETERMINANTS

VII. SUMMARY

Brief recapitulation of most critical findings in each area discussed.

VIII. IMPRESSIONS AND RECOMMENDATIONS

IX. SIGNATURES

_____
(Teacher's Signature)

_____
(Signature of Supervisor)

STUDENT TEACHER EVALUATION SHEET

This work sheet will summarize or evaluate general progress over some period of time. In one instance only parts of the summary will be useful. In other situations the entire worksheet may be utilized.

Teacher _____ Supervisor _____

Date _____

	STRONG	SATISFACTORY	IMPROVING	UNSATISFACTORY
Evidences use of outside resources				
Selects appropriate teaching materials				
Evidences objectivity in observing and reporting behavior				
Manages teaching sessions with skill in controlling behavior				
Establishes rapport with child, evidencing sensitivity to needs and feelings, interest and respect				
Evidences adaptability, flexibility and creativity in teaching				
Applies suggestions of and asks appropriate questions of supervisor				
Presents written reports and oral staff contributions promptly and effectively				
Selects appropriate teaching procedures				
Accepts responsibility				
Evidences an ability to profit from past experiences, suggestions, directions, evaluations, etc.				

Comments:

TEACHING PERFORMANCE EVALUATION

This evaluation will summarize a specific teaching session.

Student Teacher	Supervisor
Situation Evaluated	Date

	HI	S	GN	WQ	NA
ORGANIZATION AND PLANNING					
MANAGING CHILD'S BEHAVIOR					
MAKING DECISIONS					
EFFORT CHARACTERISTICS					
RAPPORT WITH CHILD					

COMMENTS:

LEGEND: HI-strong; S-satisfactory; GN-guidance needed (help from supervisor); WQ-with qualification; NA-does not apply.

Clinic for Exceptional Children

Evaluation Form: Please answer the following questions as sincerely as possible. Thank you for your cooperation.

1. Please list (in order of difficulty) problems that you have encountered as a clinical teacher during the past semester.

2. Please indicate your reactions to your supervisor (give his or her name) and elaborate specific strengths or weaknesses of this individual.

3. Please indicate your reaction to the parent-training program, and elaborate specific strengths or weaknesses of the parent-trainer.

4. Please indicate your reaction to other supportive staff, including Dr. Rutherford.

5. How would you improve our program if you were given a position of authority?

Use other side - if needed

6. What has been your overall reaction to the Master's program here at U.S.C.?

7. What has been your reaction to the caliber of the faculty?

8. What classes would you recommend adding to either the Master level class options, or Doctoral level courses?

9. Any additional comments, suggestions, or criticisms that will help us in planning for the upcoming semester?

THANK YOU FOR YOUR HELP
THIS FORM SHOULD BE ANNONYMOUS

The staff has found the following publishing companies' catalogues helpful in ordering materials for the Preschool.

Childcraft
Bayonne, New Jersey

Creative Education
Fort Worth, Texas

Creative Playthings
Princeton, New Jersey

Developmental Learning Materials
Niles, Illinois

School Supply
Atlanta, Georgia

Eye Gate Materials
Jamaica, New York

Form Sculpture for Play
Cucamonga, California

Franklin Watts
New York, New York

Game Time
Litchfield, Michigan

Ideal
Los Angeles, California

Mind/Matter
Danbury, Connecticut

School Days Equipment
Los Angeles, California

Skill Development Equipment
Anaheim, California

Troll Associates
Mahwah, New Jersey

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